(2) In applying the provisions of §§ 422.208 and 422.210, references to ''M+C organization'', ''CMS'', and ''Medicare beneficiaries'' must be read as references to ''MCO or PHP'', ''State agency'' and ''Medicaid recipients'', respectively.

(i) *Advance directives.* (1) All MCO and most PHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures with respect to advance directives. This requirement does not apply to PHP contracts where the State has determined such application would be inappropriate, as described in § 438.8(a)(2).

(2) The MCO or PHP must provide adult enrollees with written information on advance directives policies, and include a description of applicable State law.

(3) The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

(j) *Special rules for certain HIOs.* Contracts with HIOs that began operating on or after January 1, 1986, and that the statute does not explicitly exempt from requirements in section 1903(m) of the Act are subject to all the requirements of this part that apply to MCOs and contracts with MCOs. These HIOs may enter into comprehensive risk contracts only if they meet the criteria of paragraph (a) of this section.

(k) *Additional rules for contracts with PCCMs.* A PCCM contract must meet the following requirements:

(1) Provide for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions.

(2) Restrict enrollment to recipients who reside sufficiently near one of the manager's delivery sites to reach that site within a reasonable time using available and affordable modes of transportation.

(3) Provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

(4) Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

(5) Provide that enrollees have the right to disenroll from their PCCM in accordance with § 438.56.

(l) *Subcontracts.* All subcontracts must fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(m) *Choice of health professional.* The contract must allow each enrollee to choose his or her health professional in the MCO to the extent possible and appropriate.

§ 438.8 Provisions that apply to PHPs.

The following requirements and options apply to PHPs, PHP contracts, and States with respect to PHPs, to the same extent that they apply to MCOs, MCO contracts, and States with respect to MCOs.

(a) The contract requirements of § 438.6, except for the following:

(1) Requirements that pertain to HIOs.

(2) Requirements for advance directives, if the State believes that they are not appropriate, for example, for a PHP contract that covers only dental services or non-clinical services such as transportation services.

(b) The information requirements in § 438.10.

(c) The provision against provider discrimination in § 438.12.

(d) The State responsibility provisions of subpart B except § 438.50.

(e) The enrollee rights and protection provisions in subpart C of this part.

(f) The quality assessment and performance improvement provisions in subpart D of this part to the extent that they are applicable to services furnished by the PHP.

(g) The grievance system provisions in subpart F of this part.

(h) The certification and program integrity protection provisions set forth in subpart H of this part.

§ 438.10 Information requirements.

(a) *Basic rules.* (1) Each State or its contracted representative, and each MCO, PHP, or PCCM must, in furnishing information to enrollees and

potential enrollees, meet the requirements that are applicable to it under this section.

(2) The information required for all potential enrollees must be furnished by the State or its contracted representative or, at State option, by the MCO or PHP.

(3) The information required for all enrollees must be furnished by each MCO or PHP, unless the State chooses to furnish it directly or through its contracted representative.

(4) PHPs must comply with the requirements of this section, as appropriate. PHPs that contract as PCCMs must meet all of the requirements applicable to PCCMs. All other PHPs must meet all of the requirements applicable to MCOs.

(5) The language and format requirements of paragraphs (b) and (c) of this section apply to all information furnished to enrollees and potential enrollees, such as enrollment notices and instructions, as well as the information specified in this section.

(6) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

(7) Each MCO and PHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(8) If the State plan provides for mandatory enrollment under section 1932(a)(1)(A) of the Act (that is, as a State plan option), the additional requirements of paragraph (h) of this section apply.

(b) *Language.* The State must meet the following requirements:

(1) Establish a methodology for identifying the non-English languages spoken by enrollees and potential enrollees throughout the State.

(2) Provide written information in each non-English language that is necessary for effective communication with a significant number or percentage of enrollees and potential enrollees.

(3) Require each MCO, PHP, and PCCM to make its written information available in the languages that are prevalent in its particular service area.

(4) Make oral interpretation services available and require each MCO, PHP, and PCCM to make those services available free of charge to the recipient to meet the needs of each enrollee and potential enrollee.

(5) Notify enrollees and potential enrollees, and require each MCO, PHP, and PCCM to notify its enrollees and potential enrollees—

(i) That oral interpretation and written information are available in languages other than English; and

(ii) Of how to access those services.

(c) *Format.* (1) The material must—

(i) Use easily understood language and format; and

(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(2) The State must provide instructions to enrollees and potential enrollees and require each MCO, PHP, and PCCM to provide instructions to its enrollees and potential enrollees on how to obtain information in the appropriate format.

(d) *Information for potential enrollees.*—(1) *To whom and when the information must be furnished.* The State or its contracted representative must provide the information specified in paragraph (d)(2) of this section as follows:

(i) To each potential enrollee residing in the MCO's or PHP's service area;

(ii) At the time the potential enrollee first becomes eligible for Medicaid, is considering choice of MCOs or PHPs under a voluntary program, or is first required to choose an MCO or PHP under a mandatory enrollment program; and

(iii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs or PHPs.

(2) *Required information.* The information for potential enrollees must include the following:

(i) General information about—

(A) The basic features of managed care;

(B) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in an MCO or PHP; and

(C) MCO and PHP responsibilities for coordination of enrollee care;

(ii) Information specific to each MCO and PHP serving an area that encompasses the potential enrollee's service area:

(A) Benefits covered;

(B) Cost sharing, if any;

(C) Service area;

(D) Names, locations, telephone numbers of, and non-English language spoken by current network providers, including at a minimum information on primary care physicians, specialists, and hospitals, and identification of providers that are not accepting new patients.

(E) Benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO or PHP does not cover because of moral or religious objections, the MCO or PHP need not furnish information about how and where to obtain the service, but only about how and where to obtain information about the service. The State must furnish information about where and how to obtain the service.

(e) *Information for enrollees.*—(1) *To whom and when the information must be furnished.* The MCO or PHP must—

(i) Furnish to each of its enrollees the information specified in paragraph (e)(2) of this section within a reasonable time after the MCO or PHP receives, from the State or its contracted representative, notice of the recipient's enrollment, and once a year thereafter.

(ii) Give each enrollee written notice of any change (that the State defines as ''significant'') in the information specified in paragraph (e)(2) of this section, at least 30 days before the intended effective date of the change.

(iii) Make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(2) *Required information.* The information for enrollees must include the following:

(i) Kinds of benefits, and amount, duration, and scope of benefits available under the contract. There must be sufficient detail to ensure that enrollees understand the benefits to which they are entitled, including pharmaceuticals, and mental health and substance abuse benefits.

(ii) Enrollee rights as specified in § 438.100.

(iii) Procedures for obtaining benefits, including authorization requirements.

(iv) Names, locations, telephone numbers of, and non-English languages spoken by current network providers, including information at least on primary care physicians, specialists, and hospitals, and identification of providers that are not accepting new patients.

(v) Any restrictions on the enrollee's freedom of choice among network providers.

(vi) The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.

(vii) The extent to which, and how, after-hours and emergency coverage are provided.

(viii) Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.

(ix) Cost sharing, if any.

(x) Grievance, appeal, and fair hearing procedures for enrollees, including timeframes, required under § 438.414(b).

(xi) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

(xii) Any benefits that are available under the State plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO or PHP does not cover because of moral or religious objections, the MCO or PHP need not furnish information on how and where to obtain the service, but only on how and where to obtain information about the service. The State must furnish information about how and where to obtain the service.

(xiii) Information on how to obtain continued services during a transition, as provided in § 438.62.

(xiv) The rules for emergency and post-stabilization services, as set forth in § 438.114.

(xv) Additional information that is available upon request, and how to request that information.

(3) *Annual notice.* At least once a year, the MCO or PHP, or the State or its contracted representative, must notify enrollees of their right to request and obtain the information listed in paragraphs (e)(2) and (f) of this section.

(f) *MCO or PHP information available upon request.* The following information must be furnished to enrollees and potential enrollees upon request, by the MCO or PHP, or by the State or its contracted representative if the State prohibits the MCO or PHP from providing it:

(1) With respect to MCOs and health care facilities, their licensure, certification, and accreditation status.

(2) With respect to health care professionals, information that includes, but is not limited to, education, licensure, and Board certification and recertification.

(3) Other information on requirements for accessing services to which they are entitled under the contract, including factors such as physical accessibility and non-English languages spoken.

(4) A description of the procedures the MCO or PHP uses to control utilization of services and expenditures.

(5) A summary description of the methods of compensation for physicians.

(6) Information on the financial condition of the MCO or PHP, including the most recently audited information.

(7) Any element of information specified in paragraphs (d) and (e) of this section.

(g) *Information on PCCMs and PHPs.*—(1) *To whom and when the information must be furnished.* The State or its contracted representative must furnish information on PCCMs and PHPs to potential enrollees—

(i) When potential enrollees first become eligible for Medicaid or are first required to choose a PCCM or PHP under a mandatory enrollment program; and

(ii) Within a timeframe that enables them to use the information in choosing among available PCCMs or PHPs .

(2) *Required information.*—(i) *General rule.* The information must include the following:

(A) The names of and non-English languages spoken by PCCMs and PHPs and the locations at which they furnish services.

(B) Any restrictions on the enrollee's choice of the listed PCCMs and PHPs.

(C) Except as provided in paragraph (g)(2)(ii) of this section, any benefits that are available under the State plan but not under the PCCM or PHP contract, including how and where the enrollee may obtain those benefits, any cost-sharing, and how transportation is provided.

(ii) *Exception.* For counseling and referral services that are not covered under the PCCM or PHP contract because of moral or religious objections, the PCCM or PHP need not furnish information about how and where to obtain the service but only about how and where to obtain information about the service. The State must furnish the information on how and where to obtain the service.

(3) *Additional information available upon request.* Each PCCM and PHP must, upon request, furnish information on the grievance procedures available to enrollees, including how to obtain benefits during the appeals process.

(h) *Special rules: States with mandatory enrollment.*—(1) *Basic rule.* If the State plan provides for mandatory enrollment under section 1932(a)(1)(A) of the Act, the State or its contracted representative must furnish information on MCOs, PHPs, and PCCMs (as specified in paragraph (h)(3) of this section), either directly or through the MCO, PHP, or PCCM.

(2) *When and how the information must be furnished.* The information must be furnished to all potential enrollees—

(i) At least once a year; and

(ii) In a comparative, chart-like format.

(3) *Required information.* Some of the information is the same as the information required for potential enrollees

under paragraph (d) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (h)(2) of this section, and includes the following for each contracting MCO, PHP, or PCCM:

(i) The MCO's, PHP's, or PCCM's service area.

(ii) The benefits covered under the contract.

(iii) Any cost sharing imposed by the MCO, PHP, or PCCM.

(iv) To the extent available, quality and performance indicators, including, but not limited to, disenrollment rates as defined by the State, and enrollee satisfaction.

§ 438.12 Provider discrimination prohibited.

(a) *General rules.* (1) An MCO or PHP may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO or PHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with health care professionals an MCO or PHP must comply with the requirements specified in § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the MCO or PHP to contract with providers beyond the number necessary to meet the needs of its enrollees;

(2) Preclude the MCO or PHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the MCO or PHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Subpart B—State Responsibilities

§ 438.50 State plan requirements.

(a) *General rule.* A State plan that provides for requiring Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115 of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act.

(b) *State plan information.* The plan must specify—(1) The types of entities with which the State contracts;

(2) The payment method it uses (for example, whether fee-for-service or capitation);

(3) Whether it contracts on a comprehensive risk basis; and

(4) The process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) *State plan assurances.* The plan must provide assurances that the State meets applicable requirements of the following laws and regulations:

(1) Section 1903(m) of the Act, with respect to MCOs and MCO contracts.

(2) Section 1905(t) of the Act, with respect to PCCMs and PCCM contracts.

(3) Section 1932(a)(1)(A) of the Act, with respect to the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.

(4) This part, with respect to MCOs and PCCMs.

(5) Part 434 of this chapter, with respect to all contracts.

(6) Section 438.6(c), with respect to payments under any risk contracts, and § 447.362 with respect to payments under any nonrisk contracts.

(d) *Limitations on enrollment.* The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:

(1) Recipients who are also eligible for Medicare.